TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METHODIST HOSPITAL FOR SURGERY

Respondent Name
ZNAT INSURANCE COMPANY

MFDR Tracking Number
M4-17-1690-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Zenith denied payment for the remainder of the implants used, although the Hospital provided the only invoice to which it had access and certified., under 28 T.A.C. 134.404(g)(1), that the amount shown in the invoice was the cost of the implants to the best of the Hospital's knowledge. . . . The payment calculation of 28 T.A.C. 134.404(g) is not meant to exclude payment where a provider purchases an implant form a distributor rather than a manufacturer, as providers cannot, in every case, purchase implants directly from manufacturers. Rather, the calculation requires submission of an invoice, and the corresponding certification of 28 T.A.C. 134.404(g)(1), in order to verify that the amount charged by the provider is no more than it was charged to purchase the implants themselves."

Amount in Dispute: $48,532.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is undisputed that the hospital purchased the implants from Medical Management Solutions, LLC, a distributor, and that it did not purchase the implants from the manufacturer. It is further undisputed that the hospital has not provided the carrier with the manufacturer's invoice for the implants. . . . This rule requires that if the manufacturer's invoice amount is less than the amount the facility paid the implant distributor, the facility is reimbursed at the manufacturer's invoice amount rather than the actual cost to the facility. . . . The term 'manufacturer' must be given its ordinary meaning and cannot simply be ignored or read to mean an invoice from any source. . . . The plain language of the rule limits the hospital's reimbursement for the implants to the lesser of the manufacturer's invoice amount or the net amount. . . . the *maximum* reimbursement that the hospital can receive for the implants is the *manufacturer's invoice* amount. . . . The manufacturer's invoice amount cannot be determined without the manufacturer's invoice or a certification from the implant distributor regarding the actual amount it paid the manufacturer for the implants. . . . The rule does not prohibit hospitals from purchasing implants from distributors. However, if the hospital chooses to do so, it must obtain the manufacturer's cost information form the distributor because the hospital's reimbursement is capped at the manufacturer's invoice amount."

Response Submitted by: Stone Loughlin & Swanson, LLP, Attorneys at Law

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2016 to March 6, 2016	Inpatient Hospital Services	$48,532.70	$44,978.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.210 sets out documentation requirements.
2. 28 Texas Administrative Code §133.230 sets out requirements for insurance carrier audit of medical bills.
3. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
4. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
5. 28 Texas Administrative Code §134.401 set out the division's former acute care hospital inpatient fee guideline.
6. 28 Texas Administrative Code §134.403 sets out the fee guideline for ambulatory surgery center services.
7. 28 Texas Administrative Code §134.403 sets out the fee guideline for outpatient acute care hospital services.
8. 28 Texas Administrative Code §134.404 sets out the fee guideline for inpatient acute care hospital services.
9. 3 Texas Government Code §311.01 regards construction of words and phrases.
10. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.
11. Texas Labor Code §413.015 requires that insurance carriers make appropriate payment of medical charges.
12. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 253 – IN ORDER TO REVIEW THIS CHARGE WE WILL NEED A COPY OF THE INVOICE.
    - 353 – THIS CHARGE WAS REVIEWED PER THE ATTACHED INVOICE.
    - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TREATMENT MEDICAL FEE GUIDELINE.
    - 252 – AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.
    - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
      NOTE: THIS ADJUSTMENT MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S)
    - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

    The EOB included additional remittance advice remark:

    PARTIAL PAYMENT; PLEASE RESUBMIT WITH MANUFACTURER'S IMPLANT INVOICES.

    - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
    - 375 – PLEASE SEE SPECIAL *NOTE* BELOW.
    - 112 – AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.
    - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

    The reconsideration EOB included additional remittance advice remark:

    DISTRIBUTOR'S INVOICE FOR IMPLANTS WAS SUBMITTED; PLEASE RESUBMIT WITH MANUFACTURER'S IMPLANT INVOICES.

Issues

1. Are hospitals required to submit manufacturer invoices when requesting separate reimbursement of implantables?
2. Did the insurance carrier make a proper request for additional information?
3. Did the insurance carrier audit the bill in accordance with Rule §133.230 to verify the amount certified?
4. Is the amount requested by the hospital a fair and reasonable reimbursement for the disputed implantables?
5. What is the recommended payment for the disputed health care?
6. Is the requestor entitled to additional reimbursement?

Findings

1. *Must hospitals submit manufacturer's invoices when requesting separate reimbursement of implantables*?

   The insurance carrier denied payment for disputed implantable devices with claim adjustment reason codes:

   - 253 – "IN ORDER TO REVIEW THIS CHARGE WE WILL NEED A COPY OF THE INVOICE"
   - 252 – "AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE"
   - With additional remittance advice remarks: "PARTIAL PAYMENT; PLEASE RESUBMIT WITH MANUFACTURER'S IMPLANT INVOICES," and "DISTRIBUTOR'S INVOICE FOR IMPLANTS WAS SUBMITTED; PLEASE RESUBMIT WITH MANUFACTURER'S IMPLANT INVOICES."

   Review of the division's medical documentation rule, 28 Texas Administrative Code §133.210 finds that a manufacturer's invoice is not listed as documentation required to be submitted with the medical bill.

   The requirement that invoices be submitted with the medical billing was eliminated with the adoption of the former *Acute Care Inpatient Hospital Fee Guideline*, at 28 Texas Administrative Code §134.401, effective August 1, 1997.

   In the adoption preamble to that fee guideline, the former commission (now the division) explained:

   > The new ACIHFG does not require that an invoice be submitted for reimbursement of implantables, orthotics, and prosthetics to avoid an unnecessary administrative burden for hospitals and carriers. In most situations, insurance carriers will know the usual cost of such items without examining the invoice for a particular item. Even though invoices are not required by this ACIHFG, the insurance carrier still has the option of auditing the bill from a hospital and requesting additional documentation, records, or information related to the treatments, services, or the charges billed. Attaching invoices to the bill for implantables, orthotics, and prosthetics requires additional time and expense for hospitals. TWCC believes there is a need for a determination of cost for implantables, orthotics, and prosthetics to a hospital. This need however, is outweighed by the significant burden to hospitals to continue this requirement. Therefore, this is no longer a requirement.
   > (22 *Texas Register* 6278; July 4, 1997)

   In addressing public comments on that fee guideline, the commission responded to a system participant who disagreed with the elimination of the requirement, stating it is difficult for carriers to determine the cost to the facility without the invoice. The commission responded:

   > Even though invoices are not required by this guideline, the insurance carrier still has the option of auditing the bill from a health care provider and requesting additional documentation, records or information related to the treatments, services, or the charges billed. Insurance carriers are expected to not require these for all implantables, orthotics, and prosthetics and to confine it to those situations where the insurance carriers believe it is necessary to determine the cost from invoices. (22 *Texas Register* 6287; July 4, 1997)

   When separate reimbursement of implantables was first adopted as part of the revised Ambulatory Surgical Center Fee Guideline, in March, 2005 (30 *Texas Register* 1290) — using language substantially similar to the version as it appears in the current *Hospital Facility Fee Guideline--Inpatient* — the division explained in that adoption preamble:

   > The amended rule enhances consistency of reimbursement for surgically implanted devices by implementing a cost-based reimbursement, similar to the inpatient hospital methodology.
   >
   > This fee guideline requires that provider billing must include a certification statement that the amount sought represents its actual costs (net amount, exclusive of rebates and discounts). This information should facilitate the billing process by providing cost information with the original billing. Consequently, processing times should improve, and confusion related to implant costs should decrease, which should additionally decrease the opportunity for disputes. The implant cost certified by the ASC is subject to insurance carrier or commission audit and verification.
   >
   > The ability to audit is an important check and balance feature related to reimbursement of the invoice cost. The audit allows the carrier to verify the actual cost of an item and auditing and assists the commission in the statutory requirements related to effective medical cost control. Additionally, members of the ASC Focus Group agreed that auditing was an acceptable trade off when combined with additional reimbursement.
   > (30 *Texas Register* 1299; March 4, 2005)

The current *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404(g), specifies what documentation the facility must submit with the medical bill, and further gives the insurance carrier the option to audit, while paragraph 3 is explicit that *nothing* in the rule precludes the use of an implant provider:

(1) A facility . . . shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

In the January 11, 2008 adoption preamble to the current version of Rule §134.404, a commenter suggested:

> additional documentation on the billed implant should be specific down to the implant serial number so that this information can be adequately tracked and to provide for sufficient audit opportunity. At a minimum, this should include the invoice, the operative report, and the hospital inventory sheet. (33 *Texas Register* 421)

However, after duly considering this comment, the division rejected the suggestion to add further documentation requirements, stating: "The Division declines to require additional documentation." (33 *Texas Register* 421)

Moreover, in the August, 2008 adoption preamble to the final version of the current ASC fee guideline, the division specifically *removed* a revision to ASC Rule §134.402(g)(1)(B) that had been included in the published rule proposal. The rejected change would have added a requirement that the provider submit a copy of the invoice with the bill for implants. The final rule, as adopted, however, did not require any invoice.

In removing the proposed revision from the final adopted language of the ASC rule, the division stressed that documentation requirements are established in Rule §133.210 — additionally emphasizing the division's intention that rules for separate reimbursement of surgically implanted devices remain consistent across all facility settings:

> In response to comments from interested parties, and in consultation with the Medical Advisor, the Commissioner has adopted this section with a change to the proposal as published.
>
> Language in subsection (g)(1)(B) of this section that required a facility or surgical implant provider, when requesting separate reimbursement for a surgically implanted device, to attach a copy of the invoice that supports actual cost to the facility or surgical implant provider is deleted in its entirety. This change from proposal is made as a result of public comment and to clarify the requirements that providers are required to provide documentation of the cost of the implantable through §133.210 of this title (relating to Medical Documentation). Section 133.210(c)(4) of this title establishes that a provider should include with its bill any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR) and the exact description of the health care provided. Since surgically implanted devices do not have an established MAR, §133.210(c)(4) of this title applies. Stating the proposed subparagraph (B) in the rule is duplicative of the requirements of §133.210 of this title. Additionally, the deleted language created a perceived conflict or inconsistency with the implantable billing requirements in §134.403 and §134.404 of this title. It is the Division's intent to maintain consistency in all facility settings for the billing and reimbursement processes concerning separate reimbursement of surgically implanted devices. (33 *Texas Register* 6835)

The sole documentation requirement established in Rule §134.404(g)(1) requires the provider to include with the billing a *certification* that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for implantable items. The division makes clear in the adoption preamble to current Rule §134.404 that such certification should be of the actual cost for which the hospital is seeking reimbursement:

> The Division clarifies that the required certification is related to the invoice amount for which the facility or implant provider is seeking reimbursement. (33 *Texas Register* 421)

In light of the above history and analysis, the division concludes the provider is not *required* to provide a copy of the *manufacturer's* invoice with the submitted billing.

This finding is consistent with the State Office of Administrative Hearings' decision in Docket No. 45-11-2791.M4, *Trophy Club Medical Center v. Netherlands Insurance Company*. The ALJ in that decision found the documents provided by the hospital in that case — which were similar to the documentation provided by the hospital in this dispute — was sufficient to meet rule requirements to support reimbursement of the requested amount.

The respondent, however, asserts the SOAH decision "did not analyze the question presented here which is whether an invoice from an implant distributor satisfies the requirements of the rule capping reimbursement at the *manufacturer's invoice* amount."

Be that as it may, the division finds that SOAH held "the rules do not require any greater documentation" than what was provided by the hospital in that case and similarly by the hospital in this dispute. The division concurs with SOAH's ruling that an insurance carrier may not impose any greater documentation requirements on the health care provider than those set out in the division's rules or as provided by statute.

The respondent's question regarding a reimbursement cap is addressed further, below.

2. *Did the insurance carrier make a proper request for additional information?*

On April 14, 2016, the insurance carrier requested additional information from the hospital, pursuant to Rule §133.210(d), requesting "Manufacturer's invoices for all implants" with the additional comment that "the invoice submitted from Medical Management Solutions, LLC appears to be from a distributor, not a manufacturer."

Review of the insurance carrier's request for additional information finds the request does not meet the requirements of Rule §133.210(d)(5) — which states that any request by the insurance carrier for additional documentation to process a medical bill shall "be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider."

Review of the submitted information finds that the requested manufacturer's invoices were *not* contained in or in the process of being incorporated into the injured employee's records maintained by the hospital. Rule §133.210(d) does not permit the insurance carrier to require the hospital to produce records that are not in the hospital's possession. Consequently, the insurance carrier request for additional documentation of the "Manufacturer's invoices for all implants" is not supported.

3. *Did the insurance carrier audit the bill in accordance with Rule §133.230 to verify the amount certified?*

So where does that leave us? Nothing in the rules requires the hospital to submit copies of the original implant manufacturer's invoices — or at least, does not require such records to be submitted as supporting documentation with the medical bills, and does not require the hospital to produce such records in response to an insurance carrier's request for additional information — if such information is not contained in the medical or billing record. And yet, the respondent insists the MAR cannot be determined without such information, stating:

> The plain language of the rule limits the hospital's reimbursement for the implants to the lesser of the manufacturer's invoice amount or the net amount. . . . the *maximum* reimbursement that the hospital can receive for the implants is the *manufacturer's invoice* amount. . . . The manufacturer's invoice amount cannot be determined without the manufacturer's invoice or a certification from the implant distributor regarding the actual amount it paid the manufacturer for the implants.

The solution is found in Rule §134.404(g)(2), which provides the mechanism for insurance carriers to verify the amounts certified by a hospital:

> A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection.

Review of the submitted information finds no information to support that the insurance carrier exercised the option to audit the medical bill in accordance with the requirements of Rule §133.230.

There is no doubt that the insurance carrier reviewed the bill in accordance with its ordinary bill review processes. And while It is clear also that the insurance carrier requested additional information relating to the manufacturer's invoice amount, neither action constitutes an "audit" under the requirements of Rule §133.230.

Moreover, Rule §133.230(a) states that "An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

In order to perform an audit, Rule §133.230(b) requires the insurance carrier to give notice of its intent to audit no later than the 45th day after receipt of the medical bill. In addition to the notice requirement, the insurance carrier must pay 85% of the MAR, or of the contracted amount if there is one (there was no contract in this case), or of the *fair and reasonable* reimbursement amount in accordance with Rule §134.1. No documentation was found to support notice to the hospital of the insurance carrier's intent to audit. Additionally, instead of paying 85% of the MAR (or of the fair and reasonable reimbursement), the insurance carrier took final action, denying payment *entirely* for the disputed implants.

If an audit is initiated, Rule §133.230(b)(4) allows the carrier additional time (up to the 160th day after receipt of the complete medical bill) to complete the audit and pay, reduce or deny.

However, Rule §134.230(a) states that "the insurance carrier may not audit a medical bill upon which it has taken final action." In denying payment for the disputed implantable items, the insurance carrier took final action. It did not send notice of the intent to audit, nor did it pay the required 85% of the reimbursement amount for the disputed implantables. As consequence of taking final action on the bill, the insurance carrier waived any further right to audit the bill and to use the audit process (whether a "desk" audit, or an "on site" audit) to seek verification that the information certified properly reflects the requirements of the rule(s).

If the carrier does not invoke the audit process under Rule §133.230 to seek verification of the information certified under Rule §134.404(g)(1), then Rule §134.404(g)(2) *presumes* that the amount the hospital has certified properly reflects the requirements of the fee guideline. Accordingly, in the absence of an audit to establish otherwise, the information certified by the hospital is what the carrier must use to calculate payment.

The respondent argues:

> The plain language of the rule limits the hospital's reimbursement for the implants to the lesser of the manufacturer's invoice amount or the net amount. . . . the *maximum* reimbursement that the hospital can receive for the implants is the *manufacturer's invoice* amount. . . . The manufacturer's invoice amount cannot be determined without the manufacturer's invoice or a certification from the implant distributor regarding the actual amount it paid the manufacturer for the implants.

Although the division is skeptical as to the respondent's proposed reimbursement cap, we need not address that question here. Because the insurance carrier chose not to audit the bill, the information certified by the facility is presumed to properly reflect the requirements of the fee guideline. As a consequence, the insurance carrier may not further challenge or seek to verify whether the information certified meets rule requirements.

Lastly, Rule §134.404(g)(2) allows that "Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title." So that there be no confusion or lingering question, pursuant to Rule §134.404(g)(2), the division now considers whether the information certified under paragraph §134.404(g)(1) properly reflects rule requirements. Based on the documentation submitted to MFDR, the division finds by a preponderance of the evidence that the information certified by the hospital properly reflects rule requirements.

4. *Is the amount requested by the hospital a fair and reasonable reimbursement for the disputed implantables?*

Under an alternative analysis, where a MAR cannot be determined, 28 Texas Administrative Code §134.1(e)(3) requires that — in the absence of an applicable fee guideline or a negotiated contract — medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount.

The insurance carrier paid $0.00. The division finds this amount to be neither a fair nor reasonable reimbursement for the disputed health care.

Additionally, Texas Labor Code §413.015(a) requires that "Insurance carriers shall make appropriate payment of charges for medical services provided under this subtitle."

The division further finds that paying $0.00 is not an appropriate payment of charges in accordance with the requirements of Labor Code §413.015(a).

Rule §133.307(d)(2)(E)(v) further requires that the insurance carrier's response shall include "documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 . . . of this title if the dispute involves health care for which the division has not established a MAR or reimbursement rate, as applicable." The insurance carrier submitted no information to support that its payment of $0.00 was fair or reasonable. Accordingly, the respondent has not met the requirements of Rule §133.307(d)(2)(E)(v).

The requestor, on the other hand, has submitted sufficient evidence to support that the payment sought is a fair and reasonable rate of reimbursement.

Additionally, this amount is concordant with the division's intent, as stated, in the January 11, 2008 adoption preamble to the current *Hospital Facility Fee Guideline--Inpatient*, Rule §134.404, that hospitals be reimbursed their actual costs for implantables, plus an allowance for administrative expenses associated with ordering, processing and maintaining inventory of the devices as addressed by the add-on amount specified in the rules:

> a thorough understanding of the issues and costs relative to implantable devices is important in determining a fair and reasonable reimbursement rate for the workers compensation system. The workers compensation patient mix is different than the Medicare patient mix. Musculoskeletal injuries are the predominant diagnosis in the workers' compensation system. Although these types of injuries are present in the Medicare system, other age related diagnoses are prevalent in the Medicare system. Having access to surgically implanted devices for procedures related to these musculoskeletal injuries is crucial in facilitating appropriate and timely treatment and improving return to work outcomes. The costs of surgically implantable devices included in the Medicare DRG system may not fully recognize the costs of specific surgically implantable devices critical for the workers compensation patient mix. As a result the Division has attempted to assure access to and adequate reimbursement for surgically implanted devices by establishing a methodology that identifies and reimburses for the actual cost of the implantable. Additionally, the Division agrees that there are administrative costs associated with ordering, processing and maintaining inventory of these surgically implantable devices. These costs are generally addressed in the add-on allowance for separately billed and reimbursed implantables. (33 *Texas Register* 416)

Although, it must also be noted that this alternative analysis under the fair and reasonable reimbursement provisions of Rule §134.1 is not necessary in this dispute — as the payment amount *can* be determined according to the formula in Rule §134.404(g). In the absence of an audit, the insurance carrier cannot rebut the presumption under Rule §134.404(g)(2) that the amount certified by the hospital meets the requirements of the rule(s).

Nevertheless, under either analysis, the division finds the preponderance of the evidence supports the amount sought by the hospital as reimbursement. Whereas the respondent has failed to support the insurance carrier's payment of $0.00 for the disputed implantables.

5. *What is the recommended payment for the disputed health care?*

This dispute regards Inpatient hospital facility services provided to an injured employee with payment subject to 28 Texas Administrative Code §134.404(f), requiring that the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, published annually in the Federal Register, as modified by division rules. Information regarding Medicare IPPS formulas and factors is available from http://www.cms.gov.

The hospital has requested separate reimbursement of implantables in accordance with Rules §134.404(g) and §134.404(f)(1)(b). As found above, the hospital has submitted the documentation required to support that the information certified reflects the requirements of the rules.

Per Rule §134.404(f)(1)(B), the Medicare facility specific amount (including outlier payments) shall be multiplied by 108% when the facility requests separate reimbursement of implantables.

Per Rule §134.404(f)(2), the facility's billed charges shall be reduced by the amounts charged for any separately reimbursed implantables when calculating outlier payments. The total charges for the reimbursed implantables were $68,057.00. This amount is subtracted from the facility's total charges for the purpose of calculating outliers.

Additionally, the bill indicates discharge status code 6, signifying a post-acute care transfer to home care services. Transfer to certain post-acute care settings is taken into consideration in calculating reimbursement in accordance with Medicare's discharge transfer payment policy — which may adjust the final facility specific amount when the patient is discharged before one day less than the geometric mean length of stay for the DRG.

Review of the submitted medical bill and supporting documentation finds that the DRG code assigned to the disputed services is 454. The services were provided at Methodist Hospital for Surgery in Addison, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the division determines that the Medicare facility specific amount is $46,536.99. This amount multiplied by 108% results in a MAR of $50,259.95.

The implantable items as identified by the itemized statement and invoices are:

- "INFUSE BONE GRAFT SMALL" as identified in the itemized statement and labeled on the invoice as "BONE GRAFT KIT 7510200 INFUSE SMALL" – cost per unit: $3,230.10; total cost: $3,230.10
- "DBC OSTEOSTRIP 26X19X7MM" as identified in the itemized statement and labeled on the invoice as "26mm x 19mm x7mm Osteostrips" – cost per unit: $2,430.00 at 3 units; total cost: $7,290.00;
- "DBM CANCELLOUS CHIPS 15CC" as identified in the itemized statement and labeled on the invoice as "15cc Cancellous Crushed Chips" – cost per unit: $765.00 at 2 units; total cost: $1,530.00;
- "BACTERIN DBM PUTTY 10CC" as identified in the itemized statement and labeled on the invoice as "10cc DBM Putty" – cost per unit: $2,160.00; total cost: $2,160.00
- "SCREW POLY-REDUCTION 6.0X45MM" as identified in the itemized statement and labeled on the invoice as "6.0mm x 45mm Poly Reduction Pedical Screw" – cost per unit: $2,646.00 at 2 units; total cost: $5,292.00;
- "SET SCREWS" as identified in the itemized statement and labeled on the invoice as "Set Screws" – cost per unit: $621.00 at 6 units; total cost: $3,726.00;
- "DISC SHIMS" as identified in the itemized statement and labeled on the invoice as "Disc Shims" – cost per unit: $100.00 at 3 units; total cost: $300.00;
- "SCREW LUM POLY REDUCT 7.0X45MM" as identified in the itemized statement and labeled on the invoice as "7.0mm x 45mm Poly Reduction Pedical Screw" – cost per unit: $2,646.00 at 2 units; total cost: $5,292.00;
- "SCREW LUM POLY REDUCT 8.0X40MM" as identified in the itemized statement and labeled on the invoice as "8.0mm x 40mm Poly Reduction Pedical Screw" – cost per unit: $2,646.00 at 2 units; total cost: $5,292.00;
- "CAGE LLIF LUM PEEK 10X50MM" as identified in the itemized statement and labeled on the invoice as "10mm, 50mm Lateral Parallel PEEK Cage" – cost per unit: $11,340.00; total cost: $11,340.00
- "ROD BENT TI 5.5X70MM" as identified in the itemized statement and labeled on the invoice as "5.5mm x 70mm Pre Bent Rod (T)" – cost per unit: $540.00 at 2 units; total cost: $1,080.00.

The total net invoice amount (exclusive of rebates and discounts) is $46,532.10. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $2,000.00. The total recommended reimbursement amount for the implantable items is $48,532.10.

Alternatively, under a fair and reasonable analysis, pursuant to the general reimbursement provisions of Rule §134.1, this same amount is found to be a fair and reasonable reimbursement for the disputed implantable items in accordance with the requirements of Rule §134.1(f).

The sum of the MAR and recommended amount for implantable items is $98,792.05. This is the total allowable reimbursement for all services and items in dispute.

6. *Is the requestor entitled to additional reimbursement?*

The total allowable payment for the services and items in dispute is $98,792.05. The insurance carrier has previously paid $53,813.06. The amount due to the requestor is $44,978.99. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $44,978.99.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $44,978.99, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 16, 2017
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	June 16, 2017
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.